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February 27, 2015

**Testimony of Sheldon Toubman Regarding the Governor's Proposed Cuts to the Already Severely Under-Resourced Department of Social Services**

Senator Bye, Representative Walker and Members of the Appropriations Committee:

My name is Sheldon Toubman and I am a staff attorney with New Haven Legal Assistance Association. I am here this evening to testify against the many severe cuts to the social services safety net administered by DSS, as contained in the governor's proposed budget. These cuts would further unravel the safety net which the legislature has worked so hard to construct and protect. I discuss many of the worst provisions of the proposed cuts below, but first I think it is important to note what an administrative disaster DSS **already** is, undermining the social safety net, without even contemplating these proposed further cuts.

The problems with the agency affect nearly every aspect of its eligibility processing and customer service. Here are just some of the problems:

- Being cut off of medical or food benefits (Medicaid or SNAP) despite timely submitting redetermination forms showing they are still eligible
- **Trying to reach the DSS call center and waiting for over an hour or even two hours before they can reach a human** (or having to discontinue the call because they ran out of time or out of cell phone minutes)
- Applying for Medicaid (HUSKY A or D) through Access Health CT and getting a notice saying they are on Medicaid immediately, but not being able to actually get health services because providers, including pharmacies, say their computers show they are not eligible for Medicaid
- Applying for Medicaid through Access Health CT and being told they applied through the wrong place and should apply all over again through DSS on a different form
- Going to a DSS regional office to apply for medical, food or cash benefits (Medicaid, SNAP or TFA) and **being turned away from applying that day**—told to come back another day or call the call center because they got there too late in the day- which could be as early as 9:30 AM
- Requesting a DSS hearing because of a denial or termination of benefits, and waiting months for a hearing date and even longer to get a hearing decision

At bottom, many of these problems can be remedied, either substantially or entirely, by additional staff. The level of staffing is wholly insufficient to meet the current need, given how grossly understaffed the agency was when the Malloy Administration took over in 2011, how dramatically the caseloads have increased particularly for Medicaid and SNAP, and how few staff have been added by the administration.

Today, there are about **915** DSS eligibility workers, including supervisors. This needs to be put in context:

- In 2002, 13 years ago, DSS had **845** eligibility workers and supervisors, and then the number of workers dropped dramatically as successive administrations took no action to replace departing or transferring workers.

- The Malloy administration, under pressure from two class action lawsuits concerning untimely processing of Medicaid and SNAP applications, did hire a total of about 240 new employees, over two and half years, bringing it to about 8% more staff than the agency had in 2002.

- But during this same period, caseloads have dramatically increased, with an increase from about 326,000 to about 750,000 Medicaid enrollees, almost a **tripling** of enrollment.

- During the same period, SNAP enrollment has doubled.

Given these facts, even DSS's own high level recent consultant, Stanley Stewart, said DSS doesn't have enough staff to do the work. As he was quoted in a recent article:

> "If you don't have enough people to do both, that's what happens," Stewart said of prioritizing SNAP cases while lagging on Medicaid. "***Of course they need more staff. There's just not enough people to do it***."

(http://ctmirror.org/2014/12/08/thousands-got-medicaid-without-dss-ensuring-they-were-still-eligible/)

So what DSS clearly needs, in addition to a new computerized eligibility system for all programs (called "IMPACT"), which is years away, is what the Department has been instructed not to ask for: **more staff**.

But, despite this severe understaffing, the Governor's budget actually proposes **closing** a DSS office (Torrington) and **reducing** staff (by 13 FTEs), which will make matters even worse. What closing a DSS office really means is that, when individuals in the area wrongly receive notices saying they are being terminated from benefits because they did not timely submit redetermination paperwork (when of course they have done so), they will no longer have the option of going to the DSS office to speak to a worker to get the matter fixed; their only recourse will be an hour or two wait on the call center line, assuming they even have the available minutes to do this.

Many of the other cuts in the Governor's budget are listed at the end of my testimony, but I particularly would like to call your attention to three of them. It would:

- **Eliminate HUSKY A eligibility for adults (parents, pregnant women and caretaker relatives) with incomes above 138% of the FPL ,** on the theory they can instead buy insurance on the exchange, Access Health CT. In fact, for this income group and these size families, insurance on the exchange will generally be unaffordable, so they either will drop coverage entirely or avoid receiving certain needed treatments with high copays. In a neighboring state, Rhode Island, a similar cut resulted in at least half of the

terminated enrollees joining the ranks of the uninsured. Since the assumption that alternative coverage is available to these individuals is faulty, the proposal should be rejected as a dramatic cut to the health safety net for vulnerable families.

- **Require a discretionary reduction to Medicaid provider rates in the amount of $43 million and $47 million**, which means a cut of about **double** that when the reduction in matching federal dollars is included. This is said not to impact primary care services but would definitely result in cuts to other providers, like specialists. As much of a problem as DSS administrative processing is, it has actually done a very good job on the health care delivery side, both in improving quality and saving money. Access to care has significantly improved, from a combination of moving away from capitated MCOs with high overhead, implementing patient-centered medical homes (PCMHs) and raising some provider rates. Cutting provider rates now would undermine this important success of DSS and this administration, of which we should all be proud.

- **Require dually eligible (Medicare/Medicaid) enrollees to shoulder the full cost of unaffordable Medicare Part D drug copays by themselves**. Currently, dual eligibles are responsible for paying up to $15 per month in Medicare co-pays for Part D-covered drugs; after that, DSS pays all copays for the month. But under this proposal, they will be responsible for covering the full costs of all of their Medicare co-pays, some of which are now $6.60 per drug. This change will easily make drugs unaffordable for these low income individuals on multiple medications, with many studies showing that even small copays of a $1 or $2 cause low income individuals to not fill prescriptions. Since this cut is only projected to save $80,000 and $90,000, but will presumably cost a lot more in increased ER and hospitalization usage when people go without critical prescribed medications because they can't afford their copays, this change will actually likely end up **costing** the taxpayers a lot of money.

Of course, in reviewing all of these devastating cuts, I understand that members of this committee are likely thinking that, while these cuts certainly are bad, "what else can we do if there is this huge deficit and we have to balance the budget, as well as comply with the spending cap?" The answer is that the Governor and the legislature have to primarily look at the revenue side, **not** the unconscionable shredding of the safety net, and the revenue side has to include increasing taxes a little on those in our state most able to afford to pay them.

As to the spending cap, I note that while the Spending Cap applies to far more than Medicaid, and overall Medicaid costs have gone up somewhat due to (intended, successful) substantial enrollment increases, Medicaid should certainly not be penalized by the cap given that Medicaid is a major fiscal **success** story, with per member per month costs well under the national norm -- and even going into negative territory at times, with an **overall trend of reduced costs** since we got rid of the MCOs and adopted PCMHs. See attached recent data from DSS. The Spending Cap should certainly not be the basis for cutting successful social safety net programs which have demonstrated great fiscal restraint.

I hope you will agree that these cuts to the safety net are just not acceptable. I urge members of this Committee to instead champion a different approach than the one being pursued by the

Governor, and that is to follow the principles of the Better Choices Coalition, which asks the General Assembly to ask more from those who can and should pay their fair share..

Thank you for the opportunity to speak with you today.

Some of the other harmful proposed cuts to the DSS budget:

- **Takes away the cost of living adjustment for TFA, SAGA and State Supplement and for two years,** and even denies individuals on Social Security and State Supplement the COLA provided by the Social Security Administration

- **Ends intake for the state-funded Connecticut Home Care Program for Elders, Category 1 to the extent a new applicant would have to require a nursing home level of care,** versus just being at risk of institutionalization.

- **Increases cost-sharing requirements under the state-funded CHCPE program, from 7% to 15%**

- **Reduces the burial allowance for SAGA recipients from $1800 to $1000.**

- **Reduces the Personal Needs Allowance for residents of long-term care facilities** –to $50 from $60 per month, which is already a very low figure that deprives these individuals of basic dignity.

- **Ends long-term efforts of stakeholder group working on a proposal to integrate Medicare and Medicaid supports and services for dual eligibles**.

- **Reduces Medicaid payments to pharmacies,** which will likely cause even more independent pharmacies, which provide home deliveries to Medicaid enrollees, to go out of business.

- **Eliminates funding** for Healthy Start, Human Services Infrastructure Community Action Program, Teen Pregnancy Prevention, Human Resource Development - Hispanic Programs and Fatherhood Initiative and Christian Community Action under the Community Services account.